SUBSTANCE USE AND RESETTLED REFUGEES:
EMERGING EVIDENCE AND IMPLICATIONS FOR PRACTICE

By

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A project presented to the faculty of The University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Public Health in the Department of Maternal and Child Health

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Approved by:

First Reader

Second Reader

Background

Substance use among refugees is a neglected area of public health and service delivery, despite far-reaching health and social consequences for individuals, families, and communities. Unprecedented levels of forced migration worldwide--over 65 million people displaced, including more than 20 million refugees--mean that refugee health will pose an ongoing, long-term challenge to both public health practitioners and providers of direct services.[1,2] The few studies conducted on substance use among resettled refugees in the United States have noted a lower prevalence of substance use among these individuals compared to U.S.-born populations.[3] However, the considerable challenges posed by conducting research with refugee populations limit the availability of comparative-level data on substance use.

Emerging evidence suggests that refugees may experience increased vulnerability to substance use due to the unique risk factors they face throughout the migration journey.[2,4] These factors include long durations spent in hazardous environments like refugee camps, high levels of trauma exposure and related mental health outcomes, challenges associated with acculturation and assimilation, and experiences of poverty, discrimination, and marginalization following resettlement.[2] Findings from a recent global systematic review suggest that, given the level of risk that refugees experience during migration, the prevalence of substance use in this population may be greatly underestimated.[2] Limited access to health services, lack of validated screening tools and routine screening protocols, and psychosocial and cultural factors may limit the detection of substance use among resettled refugees.[2] To date, research on intervention approaches has been limited, but the heterogeneity of substance use behaviors both among and within refugee groups suggests that effective interventions will likely require cultural tailoring.[5–7]

Project Impetus

At the local level, the UNC Refugee Mental Health and Wellness Initiative (based in Chapel Hill, North Carolina) has recognized substance use as a concern among some refugee groups. Anecdotal accounts suggest that substance use in local refugee communities (particularly alcohol use among refugee men from Burma) contributes to problematic outcomes such as domestic violence, child maltreatment, and driving while intoxicated. Despite these reports, formulating responses to substance use among refugees has proven challenging. A lack of data makes it difficult to estimate the prevalence of substance use in local refugee communities. Additionally, efforts to refer individuals to appropriate treatment services on a case-by-case basis have been complicated by cultural and linguistic factors, limited program and community capacity, and logistical barriers. These experiences are consistent with current literature describing the challenges faced by other service providers in their attempts to connect refugee clients to substance use treatment.[6] A recent community needs assessment conducted by the UNC Refugee Mental Health and Wellness Initiative noted that a disconnect exists between refugees and local providers in their perceptions of substance use as a community concern:

> Alcohol and substance use came up repeatedly in key-informant interviews [with members of the refugee community]. In fact, seven of the ten cited it as a major problem in the refugee community. In the aggregated rankings of mental-health related problems, alcohol/substance abuse was ranked second after depression in a sample of community members, with 50% ranking it as the number one problem. However, among area providers, alcohol and substance abuse were rarely mentioned, and ranked 5th (of 6) in the aggregated ranking of mental health-related problems. Only 1 of the 45 providers ranked alcohol/substance abuse as the number one problem facing the community.[8]

These findings indicate a need to engage with refugees to learn more about substance use norms and practices in their communities in order to formulate appropriate public health and service delivery responses. Additionally, the findings highlight a need to raise awareness among service providers about substance use as an issue of concern for refugees, and develop resources to increase their knowledge of substance use in this population.

Module Overview

This project addresses the goal of raising provider awareness by developing a learning module about substance use in refugee populations, intended for public health practitioners and service providers who work with resettled refugees. The module situates substance use among resettled refugees in the broader context of forced migration and substance use as interconnected global health challenges. It describes unique factors that may contribute to substance use among refugees, as well as epidemiological models that have been used to explain substance use onset in migrant populations. The module proposes a "social determinants of mental health" approach for responding to substance use among resettled refugees, and includes implications for practice at individual, community, and systems levels.[9,10]

A brief survey is included to gather feedback from individuals who complete the module, for the purpose of evaluating its usefulness as a learning tool and assessing their interest in further capacity-building resources (see Appendix A). The module includes links to additional learning materials as well as local and national organizations working to address refugee mental health. A narrated version of the module will be available online via the website of Leadership in Public Health Social Work Education (http://lphswe.unc.edu), a workforce development program at the UNC School of Social Work.

References

1. UNHCR. Figures at a glance. http://www.unhcr.org/en-us/figures-at-a-glance.html. Published 2015. Accessed July 15, 2016.
2. Horyniak D, Melo JS, Farrell RM, Ojeda VD, Strathdee SA. Epidemiology of substance use among forced migrants: A global systematic review. *PLoS One*. 2016;11(7):e0159134. doi:10.1371/journal.pone.0159134.
3. Salas-Wright CP, Vaughn MG. A "refugee paradox" for substance use disorders? *Drug Alcohol Depend*. 2014;142:345-349. doi:10.1016/j.drugalcdep.2014.06.008.
4. Drachman D, Halburstadt A. A stage of migration framework as applied to recent Soviet emigres. *J Multicult Soc Work*. 1992;2(1):63-78.
5. Ezard N, Oppenheimer E, Burton A, et al. Six rapid assessments of alcohol and other substance use in populations displaced by conflict. *Confl Health*. 2011;5(1):1. doi:10.1186/1752-1505-5-1.
6. McCleary JS, Shannon PJ, Cook TL. Connecting refugees to substance use treatment: A qualitative study. *Soc Work Public Health*. 2016;31(1):1-8. doi:10.1080/19371918.2015.1087906.
7. Leow DM, Goldstein M, Mcglinchy L. *A Selective Literature Review: Immigration, Acculturation & Substance Abuse*. Educational Development Center. Boston; 2006.
8. Sanders Marcus C, Byrnes R. *Community Mental Health Needs and Assets Assessment with Refugees from Burma in Orange County, NC*. Chapel Hill, NC; 2016.
9. Kim I, Kim W. Post-resettlement challenges and mental health of Southeast Asian refugees in the United States. *Best Pract Ment Heal*. 2014;10(2):63-78.
10. Kim I. Beyond trauma: Post-resettlement factors and mental health outcomes among

Latino and Asian refugees in the United States. *J Immigr Minor Heal*. 2015;18(4):740-748. doi:10.1007/s10903-015-0251-8.

Appendix A

Module Feedback

Please complete this survey to provide feedback on "Substance Use and Resettled Refugees: Emerging Evidence and Implications for Practice."

1. The content of this module advanced my knowledge

1	2	3	4	5
Strongly disagree				*Strongly agree*

2. The module kept me focused and engaged.

1	2	3	4	5
Strongly disagree				*Strongly agree*

3. Overall, this module was valuable to me.

1	2	3	4	5
Strongly disagree				*Strongly agree*

4. I would share this module with others in my organization.

1	2	3	4	5
Strongly disagree				*Strongly agree*

5. What did you like most about the module?

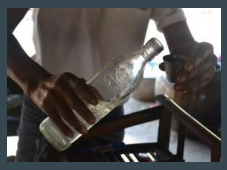
6. What did you like least about the module?

7. In what capacity do you work with resettled refugees?

8. Other comments:

Substance Use and Resettled Refugees

Emerging Evidence and Implications for Practice



Kelsey A. White
MSW/MPH Candidate
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Welcome to *Substance Use and Resettled Refugees: Emerging Evidence and Implications for Practice.* My name is Kelsey White, and I am a dual degree MSW/MPH candidate at the University of North Carolina at Chapel Hill. This learning module--developed in response to concerns raised by local refugee community members in Orange County, North Carolina--is intended for public health practitioners and service providers who work with resettled refugees.

Substance use among refugees is a neglected area of public health and service delivery, despite its health and social consequences for individuals, families, and communities. More evidence is needed about how best to identify and address problematic substance use among resettled refugees in the United States. However, reviewing the evidence that is available serves to raise providers' awareness of this issue, increase their understanding of unique factors that may contribute to substance use among resettled refugees, and suggest implications for practice at individual, community, and systems levels.

LEARNING OBJECTIVES

1. Define forced migration and substance use, and understand these issues as interconnected global health challenges.
2. Identify stages of the refugee experience and describe factors unique to refugees that may increase risk for substance use.
3. Describe epidemiological models that explain substance use among refugees at various stages of migration.
4. Recognize challenges in screening and service delivery for substance use among resettled refugees.
5. Apply the social determinants of mental health framework to substance use among resettled refugees.
6. Consider practice implications and recommendations at individual, community, and systems levels.

After completing this module, you should be able to:

1. Define forced migration and substance use, and understand these issues as interconnected global health challenges.
2. Identify stages of the refugee experience and describe factors unique to refugees that may increase risk for substance use.
3. Describe epidemiological models that may explain substance use onset among refugees at various stages of migration.
4. Recognize challenges in screening and service delivery for substance use among resettled refugees.
5. Apply the social determinants of mental health framework to substance use among resettled refugees.
6. Consider implications for practice at individual, community, and systems levels.

OVERVIEW

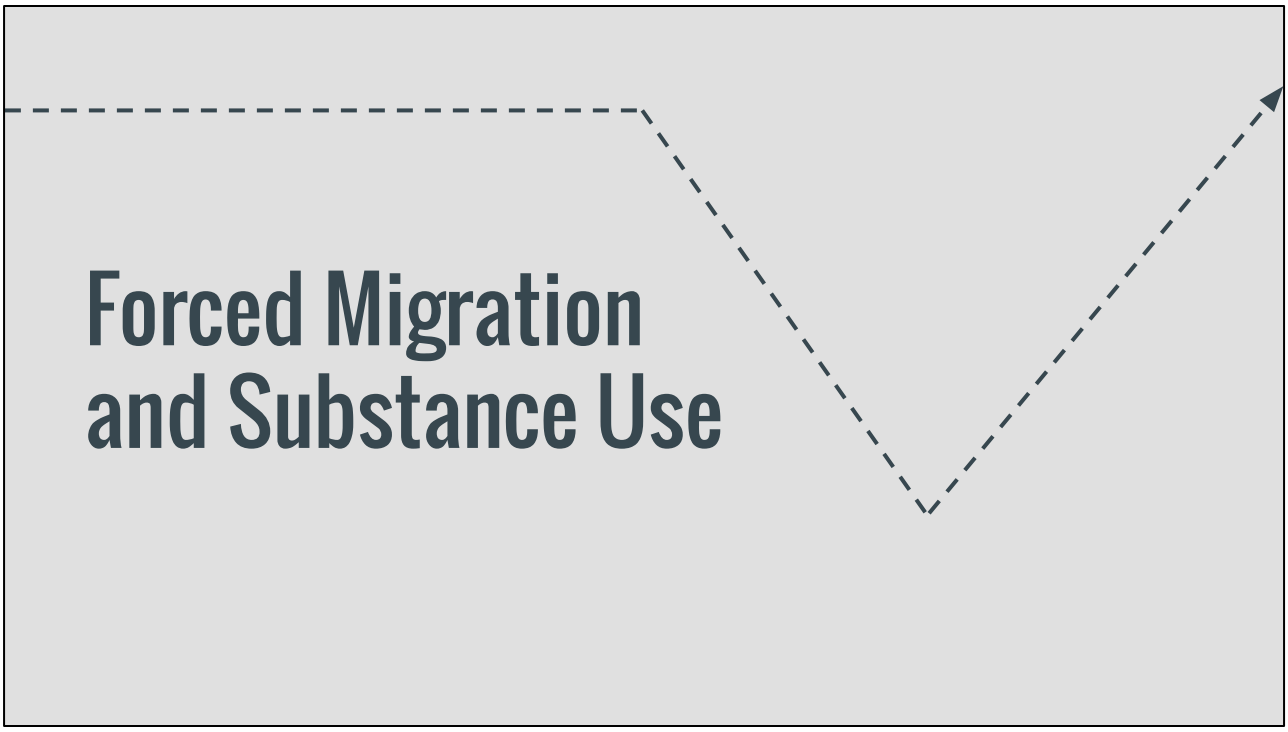
- ➔ Unprecedented levels of forced migration mean that refugee health is an ongoing, long-term challenge for the public health community and service providers[1-3]
- ➔ Emerging evidence suggests increased vulnerability to substance use among refugees; service providers increasingly recognize a need for interventions[1,4,5]
- ➔ Some refugees may be at particular risk, and those who use substances may face disproportionate negative outcomes[1]
- ➔ Addressing substance use with resettled refugees likely requires tailored approaches; cultural, logistical, and ethical factors must be considered[2,7,8]

Why is it important to understand and address substance use among refugees? Unprecedented levels of forced migration worldwide mean that refugee health--including mental health and substance use--will pose an ongoing, long-term challenge to the public health community and service providers who work with refugees.[1–3] Emerging evidence suggests that refugees may experience increased vulnerability to substance use due to the unique risk factors they face throughout migration.[1] Health and social service providers increasingly recognize the need for substance use interventions with resettled refugees.[4,5]

Substance use is a socially and culturally situated behavior, a key consideration when working with culturally diverse populations.[6] Prevalence and patterns of use vary widely between and within refugee communities, and some refugees may be at particular risk for substance use due to cultural as well as demographic, and psychosocial factors.[1] Finding effective ways to identify and address problematic substance use is crucial given that, even in communities where prevalence is low, refugees who use substances--and their families--may face disproportionate negative outcomes due to their already vulnerable health and social status.

Addressing substance use with resettled refugee communities likely requires tailored

approaches that respond to their particular needs, as well as build on cultural strengths and protective factors.[2,7,8] Interactions with public health systems and various service providers may present opportunities for prevention and intervention. At the same time, a number of cultural, logistical, and ethical factors must be considered given the potential for substance use to affect refugees' lives across a number of domains.



Let's begin with an overview of forced migration and substance use as global health challenges.

DEFINING FORCED MIGRATION

- ➔ Forced migration = movement of people displaced by conflict, disaster, or development[1,9]
- ➔ Refugee = individual forced to flee country of origin because of a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group[11]

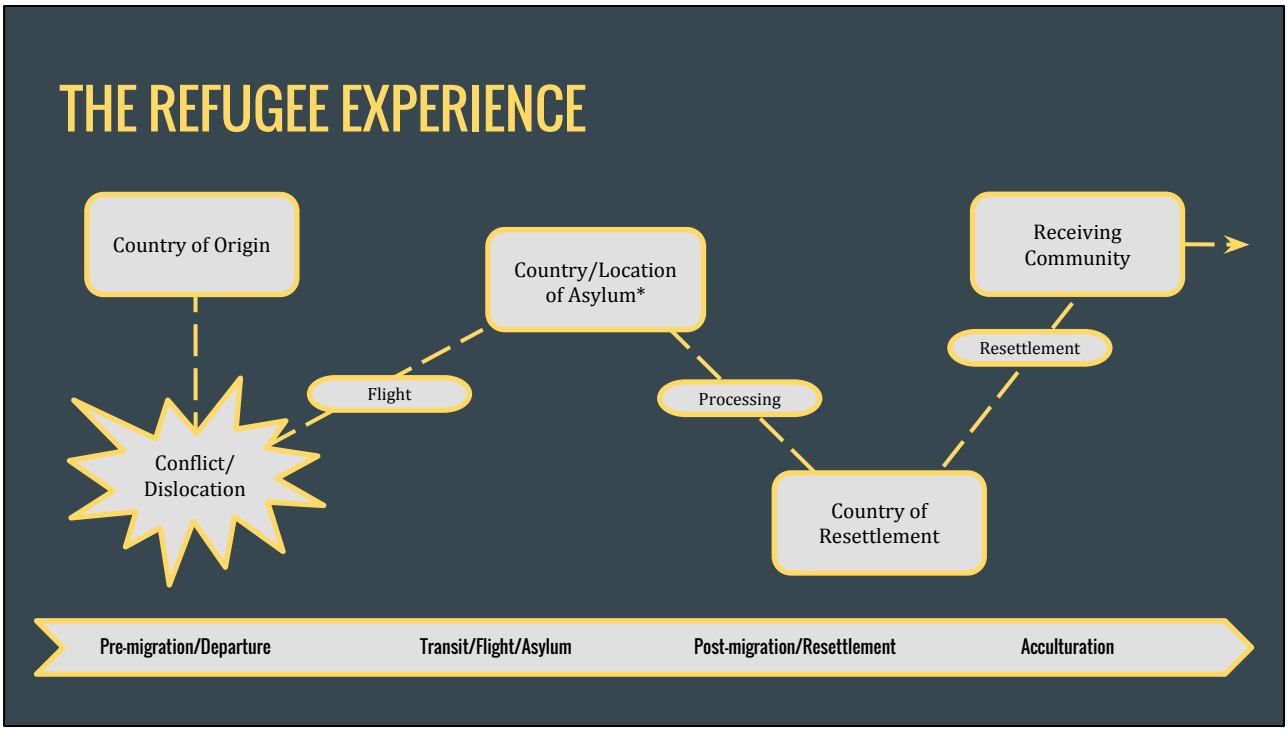
In 2015,

65 million forcibly displaced

20 million classified as refugees

Source: UNHCR, Figures at a Glance, 2015

"Forced migration" refers to the movement of people who have been displaced by conflict, disasters, or development.[1,9] Worldwide, over 65 million people have been forcibly displaced from their homes--the highest number ever recorded.[10] Of these displaced people, over 20 million are officially classified as refugees by the United Nations.[1,10] As defined by the 1951 Refugee Convention "a refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal, and religious violence are leading causes of refugees fleeing their countries."[11]



This graphic depicts the stages of the refugee experience, from country of origin to receiving community in a country of resettlement. Refugees are incredibly diverse, but they also share notable similarities that make it useful to consider their migration experience unique.[8] The refugee experience can be divided into three main stages: pre-migration/departure, transit/flight (including time spent in countries of asylum or camps), and post-migration/resettlement.[12] Acculturation, the process of adjusting to life in a new country or culture, can be considered a fourth stage.

In some ways, the refugee experience is similar to other types of migration: "any migrant must face the difficulties associated with such a major life change and will struggle to some extent with adapting to life in a new country."[13,14] Refugees, however, more often experience abrupt departures from their countries of origin as a result of conflict and violent dislocation, which can have a particular impact on their health and social status.[12]

Recognizing these stages is helpful for understanding health behaviors like substance use in the broader context of migration.[3,12] As we move through the module, keep this graphic in mind, remembering that "substance use problems [among refugees] can develop in the country of origin, in transit, in temporary refuge [or asylum], or in resettlement."[15] We will

note specific models that have been proposed to explain substance use onset at each stage of migration.

CURRENT CHALLENGES

- Long duration of displacement and asylum; demand for resettlement exceeds opportunity[1,4,16,17]
- Increasing resettlement numbers projected in United States:[18]
  - 85,000 refugees in 2016
  - 100,000 refugees in 2017
- Top countries of origin in 2016 were Democratic Republic of Congo, Syria, Burma, Iraq, and Somalia[19]
- Continued interactions in public health system and other settings[3,20]

In today's forced migration crisis, refugees increasingly remain in camps or unprotected settings for long periods of time--up to 20 years on average for some groups.[1,4,16] Demand for resettlement overwhelmingly exceeds opportunity: less than 1% of refugees worldwide are eventually resettled in a third country.[17] Among countries participating in formal resettlement programs, the United States receives the largest number of refugees, and that number is projected to increase from 85,000 refugees in 2016 to 100,000 refugees in 2017.[18] In 2016, top countries of origin among refugees resettled in the United States were Democratic Republic of Congo, Syria, Burma, Iraq, and Somalia.[19] Increasing resettlement numbers mean continued interactions with resettled refugees in the public health system and other health and social service settings.[3,20]

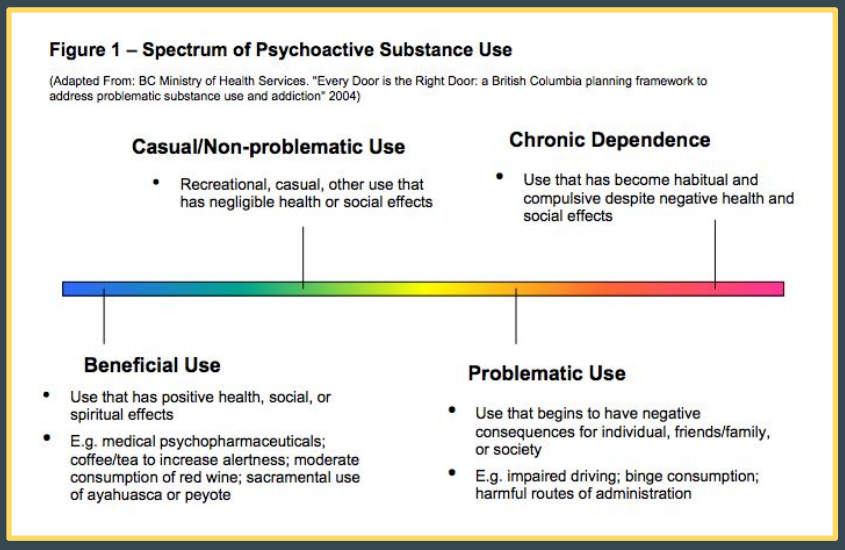
DEFINING SUBSTANCE USE

- **Substance use** = consumption of any psychoactive substance to alter mood, cope with stressors, participate in ritual or ceremony, or treat illness[21]
- **Substance use** = use of alcohol and illicit drugs, such as cannabis, cocaine, or opioids[22]
- Substance use disorder = a pattern of substance use and dependence that meets a clinical threshold (defined by DSM or ICD)
- Commonly used substances worldwide include alcohol, cannabis, cocaine, opioids, and stimulants, among others

Now that we have an overview of forced migration, let's discuss substance use as a global health challenge. Broadly speaking, substance use refers to the consumption of any psychoactive substance for the purpose of altering mood, coping with stressors, participating in ritual or ceremony, or treating illness.[21] Substance use has occurred across cultures and in various forms throughout human history. In our current context, it most often refers specifically to the use of alcohol or illicit drugs, such as cannabis, cocaine, or opioids.[22] Although tobacco is among the substances with the best-documented negative health consequences, this module focuses specifically on drugs of intoxication because of their acute health risks and potential social and legal consequences for refugees.[23]

In clinical terminology, *substance use disorders* are patterns of chronic substance use and dependence that meet clinical thresholds defined by diagnostic manuals like the DSM or ICD. Click the links here to refer to these manuals. The research literature sometimes uses these terms interchangeably, along with terms *like substance abuse*, *drug use*, and *addiction*. I have chosen to use the terms *substance use* and *substance use disorder* to align with public health terminology, reflect current clinical language, and minimize stigma by framing substance use as a health behavior that serves various functions for individuals in different

circumstances, and has determinants that can be identified and addressed to improve health outcomes.[21]



Source: Health Officers Council of British Columbia. *A Public Health Approach to Drug Control in Canada.* Victoria, British Columbia; 2005. http://www.cfdp.ca/bchoc.pdf.

Substance use exists along a continuum.[21] This continuum acknowledges *beneficial use*, such as medications taken as prescribed, or substances used for ceremonial purposes that have positive health, social, or spiritual effects for the user. Farther along the continuum is *casual or recreational use*, which has few health or social consequences, and *problematic or at-risk use,* when the user begins to have problems with health, relationships, legal involvement, or work and school performance as a result of substance use. At the far end of the spectrum is *chronic dependence*, or habitual, compulsive substance use despite negative consequences, characterized by loss of control, preoccupation with using, and physical dependence on substances. This continuum is especially important to consider when working with resettled refugees, whose cultural perceptions of substance use may differ from the medical model commonly accepted in the United States.[2]

HEALTH OUTCOMES

- Major causes of illness, injury, and death:[1,24]
  - 5.4% of global disease burden (excluding tobacco)
  - ~13 years of life lost to disability per 1,000 population
  - 39 deaths per 100,000 population
- Health behaviors and outcomes associated with substance use:[15,20,23,26-29]
  - Infectious disease (HIV, hepatitis, TB)
  - Risky sexual behavior (STIs, unplanned pregnancy)
  - Chronic disease (diabetes, hypertension)
  - Injuries (traffic-related, violence, suicide, overdose)
  - Mental health disorders (depression, PTSD)

Alcohol and illicit drug use are major causes of illness, injury, and death worldwide. To give some idea of scale, in 2010 alcohol and drug use (excluding tobacco) accounted for 5.4% of the world's total disease burden, around 13 years of life lost due to disability per 1,000 people annually, and 39 deaths per 100,000 people annually.[1,24] Alcohol alone is the third leading global disease risk, after underweight and unsafe sex.[25]

Substance use has both direct and indirect consequences for health.[15,20,26,27] It is associated with increased risk of transmission of infectious diseases like HIV and hepatitis, largely via injection drug use, as well as risky sexual behavior, which may increase likelihood of other sexually transmitted infections and unplanned pregnancy.[26–28] In addition to affecting transmission, substance use can lead to difficulty with adhering to treatment for these and other infectious diseases, like tuberculosis.[15,29]

Substance use can also contribute to or exacerbate chronic diseases like diabetes and hypertension, as well as interfere with treatment adherence for these conditions.[15] Further, substance use is implicated in both unintentional and intentional injuries. These include traffic-related injuries, violent incidents, suicide, and overdose.[15,23] Substance use often co-occurs with mental health disorders like depression or post-traumatic stress disorder

(PTSD), and can worsen these conditions as well as interfere with their treatment.[15] These consequences may be greater for some refugees due to limited knowledge of substance use and its health effects, stigma, and reduced access to health services throughout the migration experience.[1]

SOCIAL OUTCOMES

- Social outcomes associated with substance use:[8,15,23,27,30,31]
  - Gender-based violence
  - Child maltreatment
  - Reduction in household income
  - Social and economic costs of criminalization
  - Deportation and family separation

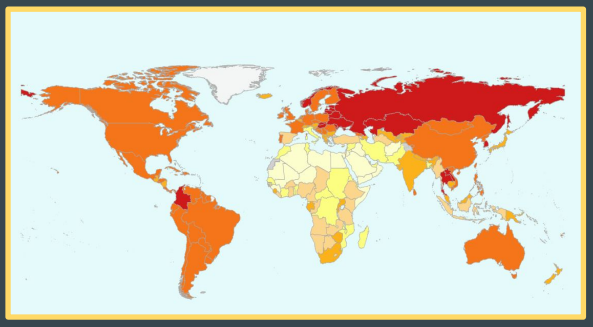
In addition to these health consequences, substance use is linked to various adverse social outcomes, including gender-based violence and child maltreatment.[15,23,27] Substance use can also lead to reduction in family income and household economic instability.[15,23] These outcomes have been specifically documented in refugee camps.[8]

Because activities related to substance use are heavily criminalized in many places, including the United States, it is associated with significant social and economic costs related to crime, arrest, and incarceration.[30] For lawful permanent residents in the United States, any drug offense can be grounds for deportation, with the exception of a conviction for possessing small amounts of marijuana.[31] For those who have not attained permanent resident status or citizenship, a drug conviction can permanently bar an individual from applying for legal immigration status.[31] A conviction for driving under the influence (DUI) can also be grounds for detention and deportation.[32] For refugees, as for other migrants, legal consequences of substance use may jeopardize immigration status and lead to family separation.[31]

ALCOHOL

- Alcohol is the most widely used substance globally:[33,24]
  - ~2 billion total users
  - 6.2 liters per capita in 2010
- Prevalence of alcohol use disorders varies widely across countries:[24]
  - Less than 1% in countries with Muslim majority
  - Over 16% in Eastern Europe
  - About 10% in Americas, Asia

Prevalence of Alcohol Use Disorders



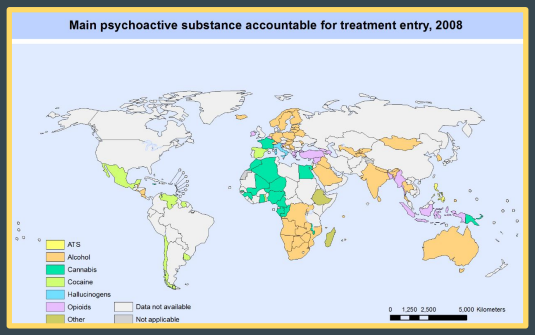
Source: WHO, 2004

Alcohol is the most widely used substance globally, with about 2 billion users worldwide.[33] This use totaled 6.2 liters of pure alcohol consumed per capita in 2010.[34] Prevalence of alcohol use disorders varies widely across countries, ranging from less than 1% in many countries with a Muslim majority (largely in the Middle East and Africa) to over 16% in some Eastern European countries; in the Americas and many Southeast Asian countries, prevalence is around 10%.[24] These variations in prevalence point to the cultural, social, and historical factors that shape patterns of substance use--including patterns of use among diverse refugee groups.[2,6] You can click on this map from the World Health Organization to explore the prevalence of alcohol use disorders in countries around the world.[35]

ILLICIT DRUGS

- Illicit drugs are used less widely; among people ages 15-64,[21,30]
  - 230 million (1 in 20) use an illicit drug at least once a year
  - 1 in 40 uses an illicit drug at least once a month
  - 27 million are reported to have a substance use disorder
  - Nearly 13 million use drugs via injection

Substances Accountable for Treatment Entry



Source: WHO, 2008

Illicit drugs are used less widely, especially compared to alcohol, but have a significant health impact. Globally, cannabis use is most common, followed by stimulant, cocaine, and opiate use.[30] Among people ages 15 to 64 worldwide, 230 million (or about 1 in 20) use an illicit drug at least once a year, 1 in 40 uses an illicit drug at least once a month, and 27 million are reported to have a substance use disorder.[30] About half of those with substance use disorders are injection drug users--particularly risky in terms of infectious disease transmission in settings where harm reduction measures like syringe exchange are not implemented.[30,21] This map from the World Health Organization shows the main psychoactive substances accountable for treatment entry in countries around the world, as reported in 2008.[36] Increasing levels of illicit drug use have been noted in low-income countries in recent years.[30] Click the map for a closer look at these patterns, and consider the countries of origin represented among resettled refugees.[36]

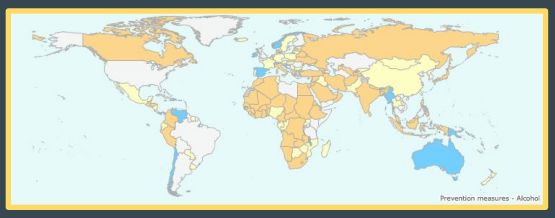
GLOBAL ACCESS TO TREATMENT

- ➔ Policy frameworks and treatment systems vary widely[24]
- ➔ Only 1 in 6 problem drug users can access treatment[30]
- ➔ Unequal access leads to more severe outcomes for those with few resources[34]

Most Commonly Used Treatment Settings

Source: WHO, 2008

Screening/Brief Interventions in Primary Care



Source: WHO, 2008

Differences in social and cultural context affect not only prevalence and patterns of substance use, but also drug control policy and systems of substance use prevention and treatment in various countries.[24] While effective interventions and strategies for the prevention and treatment of substance use disorders do exist, they are not consistently implemented. Therefore, as with other health conditions that affect refugees, the capacity of health systems in countries of origin and locations of asylum has an impact on the course of substance use in this population.[1] Globally, only one in six problem drug users has access to treatment.[30] Where there is unequal access to treatment or other resources, the health and social consequences of substance use are likely to be more severe for individuals with few resources, which often includes refugees.[34] The interactive map on the left shows the settings most commonly used to deliver substance use treatment in countries around the world--largely specialized treatment programs as opposed to general health care settings.[37] The map on the right shows which countries have implemented substance use screening and brief intervention practices into primary care, a recommended standard for substance use treatment: just 9% of countries have implemented screening and brief intervention for alcohol, while only 6% have implemented screening and brief intervention for other drugs.[38] Click on the maps to explore this data

further.

CONTINUED ORIGINAL USE MODEL

- Refugees continue original substance use patterns from countries of origin (or countries of asylum or camp settings)[14,14,39]
- May be relevant to refugees who originate from a culture or setting where there is heavy alcohol or drug use[40]

One model that has been used to explain substance use initiation among resettled refugees in the *continued original use model*, which states that refugees may continue original substance use patterns from their countries of origin (or possibly from countries of asylum, or camp settings).[13,14,39] This model may be especially relevant to refugees who originate from a culture or setting where there is heavy alcohol or drug use.[40]

MAKING THE CONNECTION

Let's take a closer look at the factors connecting forced migration and substance use, and what they could mean for resettled refugees.

THE IMMIGRANT PARADOX

- ➔ Immigrant paradox = observation that some newly arrived immigrant populations experience better health than U.S.-born population, despite adverse circumstances[1]
- ➔ Attributed to self-selection for migration and high levels of social support within immigrant communities[41,42]
- ➔ Lower prevalence of substance use compared to U.S.-born populations[1,41]
- ➔ Likelihood of legal consequences as possible deterrent to substance use[41]

Researchers have noted a so-called "immigrant paradox" in the United States; that is, some newly arrived immigrant populations experience better health than U.S.-born populations despite adverse socioeconomic circumstances usually associated with poorer health outcomes.[1] This "healthy immigrant effect" has been attributed in part to self-selection (that is, those who are able to migrate are generally healthier than non-migrants) and in part to high levels of social support within immigrant communities.[41,42] The paradox applies to substance use in that, generally, immigrant groups tend to have a lower prevalence of substance use compared to U.S.-born populations.[1,41] The likelihood of legal consequences including deportation has been proposed as one deterrent to substance use among immigrants in the United States.[41]

A REFUGEE PARADOX?

- ➔ Does the immigrant paradox apply to refugees?
  - ◆ Less likely to report alcohol and drug use disorders[1]
  - ◆ 3 to 6 times less likely than U.S.-born individuals to meet criteria for alcohol, cocaine, hallucinogen, and opioid/heroin use disorders, and 1.5 to 2 times less likely than non-refugee immigrants to meet criteria for these disorders[41]

- ➔ Key differences between refugees and voluntary migrants:[1,4,13,41]
  - ◆ Degree of self-selection and social support
  - ◆ Degree of trauma exposure
  - ◆ Length of time in high-risk environments

Does this paradox hold true for refugees? It is difficult to accurately estimate substance use prevalence among refugees due to the challenges of conducting research with this population, but in the few studies conducted specifically with resettled refugees, reported prevalence of substance use has been low. A systematic review found that, in the United States, refugees were significantly less likely to report alcohol use, injection drug use, alcohol use disorder, and most substance use disorders compared with non-refugees.[1] Additionally, analysis of data from the National Epidemiologic Study on Alcohol and Related Conditions showed that refugees were 3 to 6 times less likely than U.S.-born individuals to meet criteria for alcohol, cocaine, hallucinogen, and opioid/heroin use disorders. Refugees were also 1.5 to 2 times less likely than non-refugee immigrants to meet criteria for these disorders.[41]

Do these numbers tell the whole story? There is reason to consider that the "immigrant paradox" or "healthy immigrant effect" observed among other migrant groups may not readily apply to refugees, who by definition do not voluntarily self-select for migration but rather are relocated involuntarily and often violently.[13] This difference is a key distinction between refugees and those who choose to migrate voluntarily, as is the likelihood that newly arrived refugees may have more limited social support than voluntary migrants.[4] In addition to the

degree of self-selection and levels of social support, the degree of trauma exposure faced by refugees and the substantial periods of time they spend living in exile in hazardous environments may expose them to greater risks for substance use.[1,41]

UNDERESTIMATING PREVALENCE?

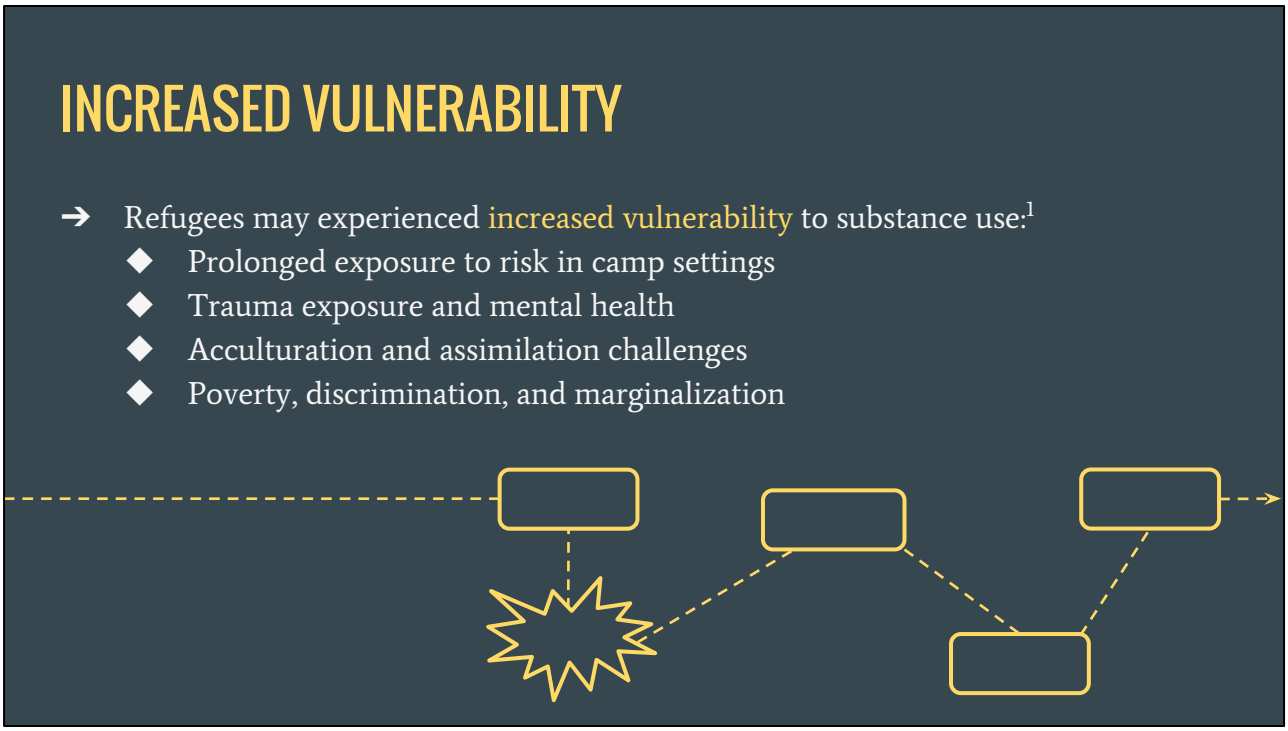
- ➔ Prevalence possibly higher than currently detected[1,2]
- ➔ Potential explanations for low prevalence
  - ◆ Overseas screening and inadmissibility[43]
  - ◆ No formal screening process during resettlement[1]
  - ◆ No standardized tools validated with refugee groups
  - ◆ Cultural norms, stigma, and barriers to disclosure[1]
  - ◆ Truly low prevalence due to protective factors[15]
- ➔ Could be a missed opportunity for prevention[1]

Emerging evidence suggests that a refugee paradox with regard to substance use may not be a foregone conclusion. In a recent global systematic review exploring the epidemiology of substance use among refugees and other forced migrants, researchers proposed that, given high-risk environments faced by refugees during migration (for example, living in camps), it is likely that substance use among newly-arriving refugees occurs at higher levels than what is currently detected and that the prevalence of substance use in resettled refugee populations is underestimated due to challenges in screening.[1,2] The review found that if upper limits of the included studies were considered, as many as a third of forced migrants may be using alcohol in ways that are harmful or hazardous; among current drinkers only, the number may be as high as two thirds.[1]

There are a number of potential explanations for low substance use prevalence among resettled refugees. First, during overseas processing for refugees applying for resettlement, a diagnosed substance use disorder with documented "harmful behavior" is grounds for inadmissibility, though there are few details about how screening procedures or stigma might affect reporting of substance use during overseas processing.[43] Therefore, it is possible that substance use may exclude some refugees from resettlement altogether. Additionally,

substance use may be underestimated because there is no formal screening process during initial resettlement, and in settings where providers may ask about substance use, cultural norms may act as barriers to disclosure.[1] To date, no standardized substance use screening tools have been validated specifically with refugee groups. Finally, it is likely the case that in some refugee groups, prevalence is truly low due to social, cultural and/or religious norms, which may act as protective factors against substance use.[15] Accurate estimates and comparisons among refugee groups are difficult to make due to a lack of available comparative-level data.[15] Still, if prevalence of substance use is indeed underestimated among resettled refugees, then it represents a missed opportunity to prevent unnecessary illness, injury, death, and disruption to communities.[1]

Now, let's move on to risk factors that may contribute to substance use among resettled refugees.



The main risk factors that may lead to increased vulnerability to substance use among resettled refugee populations are long periods of exposure to substance use in camp settings; trauma exposure and related mental health outcomes; acculturation and assimilation challenges; and experiences of poverty, discrimination, and marginalization.[1] These factors are present to varying degrees throughout the migration process. In other words, risk begins long before resettlement and continues past the initial period of resettlement. As the module continues, we will examine these factors in further detail to understand how they can contribute to substance use risk among refugees, with a focus on resettlement.

SUBSTANCE USE IN CAMPS

- ➔ Alcohol use most common in camp settings[15,23]
  - ◆ Prevalence of hazardous/harmful drinking ranged from 17% to 36%[1]
  - ◆ Among past-year drinkers only, prevalence was as high as 66%[1]

- ➔ Rapid assessments in camp settings noted patterns of use including:[15]
  - ◆ Alcohol use among refugees in Kenya and Uganda
  - ◆ Alcohol and cannabis use among refugees in Liberia
  - ◆ Opium, heroin, and cannabis use among Afghan refugees in Iran
  - ◆ Alcohol, stimulant, and opium use among refugees from Burma in Thailand

- ➔ Economic and social functions of substance use[1,15,28]

Elevated levels of substance use have been noted in some refugee camp settings, and refugees' extended time in these environments has been proposed as a major risk factor that could increase their vulnerability. Reflecting global patterns of substance use, alcohol seems to be most widely used among refugee populations living in camps.[15,23] In studies considered by a global systematic review, "prevalence of hazardous or harmful alcohol use in camp settings ranged from 17-36%, but was as high as 66% when measured among past-year drinkers only."[1] Rapid assessments of substance use in camp settings noted alcohol use among refugees living in Kenya and Uganda; alcohol and cannabis use among refugees in Liberia; opium, heroin, and cannabis use among Afghan refugees in Pakistan; and use of alcohol, stimulants, and opium among refugees from Burma living in Thai refugee camps.[15]

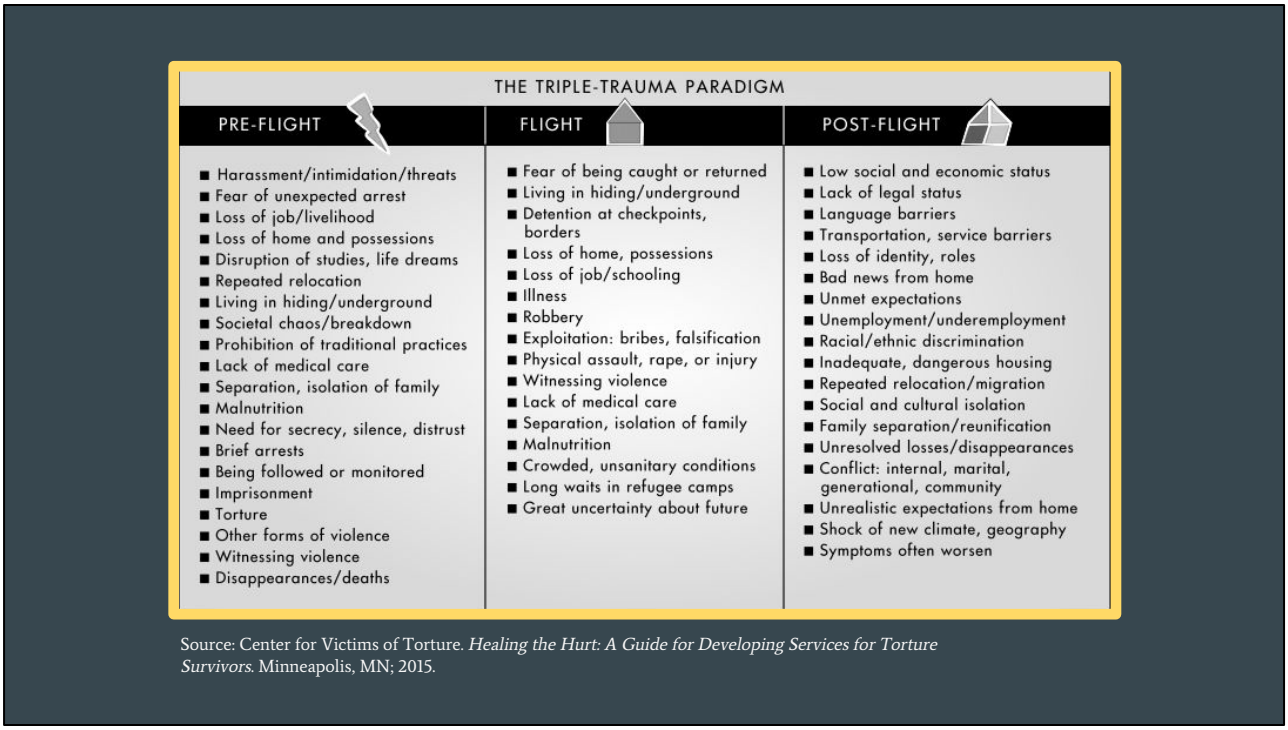
It is important to recognize the social functions that substance use and related activities may serve in camp settings, and consider how these functions could influence attitudes toward substance use after resettlement. In refugee camps, the production and trafficking of substances is sometimes part of the informal survival economy by which refugees meet their basic needs; additionally, substance use may contribute to social connectedness in some refugee groups, though it also disrupts community in others.[1,15,28] More

evidence is needed about the impact of substance use on the ability of communities to recover from conflict.[15]

TRAUMA AND MENTAL HEALTH

- ➔ Disproportionately high levels of trauma exposure among refugees[1]
- ➔ Resettled refugees up to 10 times more likely to have developed post-traumatic stress disorders compared to general population and other migrant groups[44]
- ➔ Triple Trauma Paradigm = trauma can occur at all stages of the migration process, including post-migration/resettlement[45]

Compared to the overall population and to other migrants, refugees are exposed to high levels of trauma.[1] Systematic reviews suggest that refugees resettled in Western countries like the United States are up to ten times more likely to have developed post-traumatic stress disorders, compared to the general population and other migrant groups.[44] It is critical to begin the discussion of trauma by acknowledging the Triple Trauma Paradigm, which recognizes that trauma can occur at all stages of the refugee experience--including resettlement--but that providers may tend to overemphasize pre-flight or conflict-related trauma, and underemphasize or ignore the trauma of resettlement itself.[45]



Source: Center for Victims of Torture. *Healing the Hurt: A Guide for Developing Services for Torture Survivors.* Minneapolis, MN; 2015.

This graphic lists the types of trauma that refugees may experience at each stage of migration.[45] During the *pre-migration stage,* trauma may consist of experiences like harassment, intimidation or threats; disruption of schooling; loss of job, livelihood, home and possessions; societal chaos; malnutrition, illness, and lack of medical care or other essential services; separation from family; being followed or monitored; arrest, imprisonment or torture; rape or sexual assault; and witnessing violence, disappearances, or deaths.[45,46]

The *transit/flight phase* may additionally consist of experiences like living in hiding, coping with fear of being caught or returned to the country of origin, and robbery or exploitation. As in the pre-migration phase, family separation, physical assault or injury, and rape or sexual assault may occur during transit and flight.[45,46] And, as mentioned previously, many refugees spend long periods of time in camps or other high-risk environments where these experiences may be more likely.

During the *post-migration/resettlement* phase, additional forms of trauma emerge related to adjusting to a new host country and culture: low social and economic status, language barriers, difficulty with transportation and access to services, changes in social roles, conflicts in relationships, and various other factors can reinforce trauma.[45,47]

TRAUMA AND MENTAL HEALTH

- ➔ High prevalence of depression, PTSD, and other mental health concerns[48,49]
  - For adults, 10-40% for PTSD and 5-15% for depression
  - For children and adolescents, 50-90% for PTSD and 6-40% for depression
- ➔ Distress often reported as somatic complaints[2,50]
  - Stomach pains, body pains, headaches, fatigue, lack of energy
  - Could also be related to substance use

The link between trauma and substance use is well documented among the general population, as well as among survivors of torture.[1] This evidence supports the hypothesis of increased risk for substance use among refugees: experiences of trauma contribute to mental and emotional distress, which in turn may lead to substance use as a coping strategy. Emerging evidence has begun to document comorbid mental health and substance use among forced migrant populations, including refugees.[1] In general, refugee populations have a high prevalence of psychiatric symptoms consistent with depression, posttraumatic stress disorder (PTSD), and other mental health concerns.[48] Specific clinical diagnoses may differ depending on characteristics of refugee groups and their particular experiences; however, it has been estimated that rates of PTSD among adult refugees range from 10-40%, while rates of depression range 5-15%.[49] Among children and adolescents, rates of PTSD may range from 50-90% while rates of depression range from 6-40%.[49] Refugees often report mental or emotional distress in terms of somatic or physical symptoms like stomach or body pain, headaches, and fatigue; these somatic symptoms could also be related to substance use in some cases.[2,50]

SELF-MEDICATION MODEL

- ➔ Substance use is a coping strategy for refugees who have experienced trauma[40]
- ➔ Using substances to alter mood or consciousness temporarily decreases distress[40]
- ➔ Implication that access to other resources could decrease the perceived need to cope via substance use

The *self-medication model* states that, among refugees who have experienced trauma, substance use provides a way to cope by altering mood or consciousness to temporarily decrease feelings of distress.[40] In several studies included in a global systematic review, refugees identified "self-medication of PTSD symptoms" and "coping with trauma and loss" as underlying reasons for substance use.[1] The self-medication model implies that access to other resources or options for coping could decrease the perceived need to cope via substance use.

ACCULTURATION AND ASSIMILATION

- **Acculturation** = process of cultural and psychological change that follows contact with a culture other than one's own[12]
- **Assimilation** = process by which characteristics of immigrant group members and host societies come to resemble one another[51]
- Examples of acculturation challenges include: separation from family, adjusting to changes in social roles, finding stable employment, and language learning[4,8]

The stress of acculturation and assimilation is another factor that may affect risk for substance use among refugees. Acculturation refers to the "process of cultural and psychological change that follows contact with a culture other than one's own."[12] Assimilation refers to the process by which the characteristics of immigrant groups and host cultures "come to resemble one another" over time.[51] Examples of the challenges presented by these processes include: family separation, adjusting to changes in social roles, finding stable employment, and learning a new language.[4,8] Recent evidence suggests that acculturation challenges in resettlement have a major impact on refugees' mental health and--potentially--associated behaviors like substance use.[44]

CULTURAL INTEGRATION AND RISK

- Risk for substance use may increase based on[1,15,39]
  - Low levels of integration in a host culture, leading to marginalization, or
  - High levels of integration in a host culture where substance use is normalized
- Refugees who are more assimilated to their host culture may engage in substance use in order to adhere to cultural norms or gain acceptance[7]

These processes of acculturation and assimilation are relevant to substance use because risk may increase based on either *low levels* of integration with a host culture that lead to marginalization *or* based on *high levels* of integration with a host culture where substance use (especially alcohol use) is normalized and substances are easily accessible.[1,15,39] Migrants and refugees who are more assimilated to their host culture may engage in substance use in order to adhere to new cultural norms or gain acceptance in their new communities.[7]

ACCULTURATIVE STRESS MODEL

- ➔ Substance use among refugees is reaction to the migration experience, specifically stress related to cultural conflict and a lack of social and economic resources for coping[13,39]
- ➔ Substance use is a temporary way to decrease stress related to adjusting to a new setting[40]

Based on these ideas, the *acculturative stress model* states that substance use among refugees is a reaction to the migration experience itself, specifically stress related to cultural conflict in addition to a lack of social and economic resources for coping.[13,39] According to this model, substance use occurs among refugees because it is a temporary way to decrease the stress related to adjusting to a new setting.[40]

ASSIMILATION/ ACCULTURATION MODEL

- ➔ Refugees adopt customs of host country, including patterns of substance use[13,39]
- ➔ May be relevant to individuals from countries with a low prevalence of substance use
- ➔ May serve a function of “acculturative aspiration,” or fitting into dominant norms or expectations of host culture[40]

Similar to the acculturative stress model is the *assimilation/acculturation model*, which proposes that, as refugees adopt the customs of their host country, their patterns of substance use begin to reflect patterns common in their new location.[13,39] This model may be relevant to refugees originating from countries where there is low prevalence of substance use. As we have mentioned, some researchers hypothesize that substance use serves a function of "acculturative aspiration," or fitting into dominant cultural norms or expectations of the host culture.[40]

DURATION OF RESETTLEMENT

- ➔ Substance use seems more likely to occur after the initial resettlement period[1,7,39,41]
  - ◆ Among newly arrived Iraqi refugees in the U.S., a longitudinal study showed that prevalence of lifetime alcohol use increased from 20% to 39% over 12 months[1]
  - ◆ Migrants who had been in the United States for 10 years or longer reported drug use at levels consistent with that of the U.S.-born population[7]
- ➔ Importance of maintaining contact with refugees throughout early resettlement to monitor changes in substance use; long-term contact is difficult[1,8]

Consistent with the assimilation/acculturation model, there is evidence that longer duration in the United States may contribute to increased substance use risk among resettled refugees.[1,39,41] For migrants generally, the evidence is clear that substance use is more likely to occur *after* they have lived for some time in the United States; the longer they have been exposed to U.S. culture, their physical health outcomes tend to worsen, and their likelihood of engaging in a variety of risk behaviors--including substance use-- increases.[7] There is emerging evidence to support the idea that substance use is more likely to occur after the initial resettlement period. In one example, a longitudinal study showed that prevalence of lifetime alcohol use among newly-arrived Iraqi refugees in the United States increased from 20% to 39% over 12 months.[1] Among migrants generally, "while newcomers were found to be less likely to engage in substance use than the U.S.-born population, those who had been in the United States for 10 years or longer reported drug use that was not significantly different from that of the U.S.-born population."[7] This pattern suggests the importance of maintaining contact with refugees throughout early resettlement to observe any changes in substance use as they adjust to life in the United States.[1] Unfortunately, the time-limited nature of services available to resettled refugees upon their arrival can make it difficult to maintain long-term contact.[8]

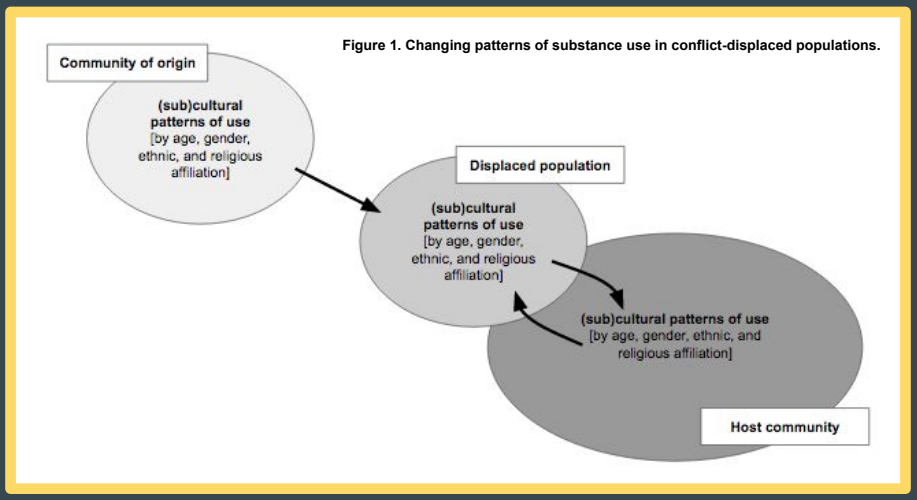
GENDER AND AGE

- Male gender noted as a risk factor for substance use[1,30,52]
  - Worldwide, substance use is more prevalent among men[30]
  - Certain subgroups of refugee women may be at increased risk[1,13]
  - Gender roles shape perceptions and patterns of substance use[26]
  - Loss of traditional gender roles can be a source of stress and conflict[2,15]
- Increased risk for substance use among youth[1,15,30]
  - A leading cause of injury and death among youth worldwide[1]
  - Stress of acculturation and assimilation during a critical period[7]
  - Substance use as a reaction to mainstream cultural norms[35]
  - High prevalence of post-traumatic stress disorder among children, youth[13]

In addition to duration of resettlement, gender and age appear to be associated with risk for substance use. Both factors are relevant to the acculturation process.

Worldwide, substance use is more prevalent among men than among women, and male gender has been noted as a risk factor for substance use among conflict-affected populations, including refugees.[1,30,52] It should be noted that women have been underrepresented in substance use research, and that certain subgroups of refugee women may be at increased risk for substance use.[1,13] Gender roles are important in shaping perceptions and patterns of substances use among diverse refugee groups. For example, in a study conducted with one group of refugees from Burma living in a camp in Thailand, risky drinking was common and normalized among men but practically nonexistent among women; this pattern was attributed to attitudes about masculinity and femininity, such as the idea that women have more self control.[26] A sense of losing traditional gender roles, particularly among refugee men, has been noted as a result of displacement.[15] In the context of resettlement, changes in gender roles that occur as part of the acculturation process can be a source of stress and conflict among couples and families, which may contribute to or be exacerbated by substance use.[2]

Increased risk for substance use has also been noted among youth, both generally and among young refugees in camp settings.[1,15,30] Substance use is a leading cause of injury and death among youth worldwide.[1] In resettlement, the stress of acculturation and assimilation may be particularly acute for youth from refugee families who are trying to reconcile cultural differences during a critical period in their development, when risk for substance use is already elevated.[7] For example, research conducted among children of migrants and refugees in Europe suggests that they may use drugs to demonstrate their rejection of, and/or exclusion from, mainstream social or cultural norms.[35] Risk for substance use may be elevated among resettled refugee youth given the high prevalence of post-traumatic stress disorder among children and youth from refugee families.[13]



Source: Ezard N, Oppenheimer E, Burton A, et al. Six rapid assessments of alcohol and other substance use in populations displaced by conflict. *Confl Health*. 2011;5(1):1. doi:10.1186/1752-1505-5-1.

Acculturation may occur several times during the migration process, particularly if refugees spend long periods of time in a country of asylum or camp after being displaced from their country of origin. This graphic shows the complex factors that contribute to substance use risk and changing patterns of substance use as refugees move through the migration process.[15] Additional evidence is needed about how these factors may result in changing substance use patterns among resettled refugees in the United States.

POVERTY, DISCRIMINATION, AND MARGINALIZATION

- ➔ Originate from settings of poverty; limited possibilities for change and control[53]
- ➔ In resettlement, refugees often face social and economic inequality:
  - ◆ Discrimination based on racism and xenophobia[1,44,47,55]
  - ◆ Low-income, disadvantaged neighborhoods[1,47]
  - ◆ Barriers to employment and financial difficulties[56]
  - ◆ Family separation and social isolation[53]
- ➔ Feelings of stress and powerlessness as important determinants of health and risk factors for substance use[7]

Experiences of poverty and discrimination may also shape risk for substance use among refugees at every stage of migration. Many refugees, though not all, originate from settings of poverty that offer “limited possibilities for change and control” over their lives and health outcomes.[53] Around the world, low-income countries host the majority of refugees seeking asylum.[54] Compared to other migrant groups, refugees tend to have fewer financial resources and less formal education, though again, this varies depending on the group and individual.[4] They face "exclusionary attitudes and poor working and living conditions” in various settings, including resettlement.[53] Refugees resettled in Western countries, including the United States, often experience discrimination based on racism and xenophobia--the idea that they are "perpetual foreigners."[1,44,47,55]

Resettled refugees also confront other forms of social and economic inequality. They are often housed in low-income or otherwise disadvantaged neighborhoods, where they may be more likely to face issues like violence and low-quality schools, as well as exposure to alcohol or illicit drugs that are readily available in these settings.[1,47] Difficulty with employment is common due to language barriers, issues related to education or training, employer attitudes, and other factors.[56] Even refugees who achieved high levels of education,

training, and career status in their countries of origin tend to have few options beyond low-wage jobs that offer limited opportunity for advancement.[56]

The U.S. approach to resettlement emphasizes "early self sufficiency" through employment, and time-limited medical and financial benefits increase the pressure for refugees to find employment early in the post-migration period.[47,57] Unemployment and financial difficulties are associated with worse resettlement outcomes, and the mental health impact may actually be greater for refugees who experience larger decreases in socioeconomic status following resettlement, such as those who are highly educated but unable to find work in their fields.[8] Resettled refugees may be marginalized due to discrimination and poverty, as well as migration experiences--like family separation--that increase social isolation.[53] “These factors have all been shown to be important determinants of health and may contribute to feelings of stress and powerlessness, which may in turn contribute to substance use."[7]

STRESS MARGINALITY MODEL

- ➔ Refugees most at risk for substance use are those who are marginalized[13,14,40]
- ➔ Have less fully integrated their own culture and the host culture or feel excluded from the dominant culture

Refugees' experiences with poverty, discrimination, and resulting marginalization form the basis for the *stress marginality model*. This model states that those most at risk for substance use are those who are marginalized—that is, those who have less fully integrated their own culture and the host culture, or who feel excluded from the dominant culture.[13,14,40]

INTRACULTURAL DIVERSITY MODEL

- ➔ Not all members of a refugee group fit neatly into one particular model[13]
- ➔ Each model addresses important aspects of substance use risk
- ➔ For an individual, substance use onset may be attributed to a combination of models[40]

Having reviewed the major risk factors for substance use among refugees, it is important to note one final model of substance use onset. The *intracultural diversity model* acknowledges, "not all members of a refugee group will fit neatly into one particular model."[13] While each of the models we have discussed address key factors contributing to substance use risk among resettled refugees, it is critical to remember that individual differences exist among members of refugee groups, and that substance use may result from some combination of all models.[40] As we have mentioned, duration of resettlement, gender, and age are some of the factors that may affect individual risk and presentation of substance use, even within a single refugee group or community.

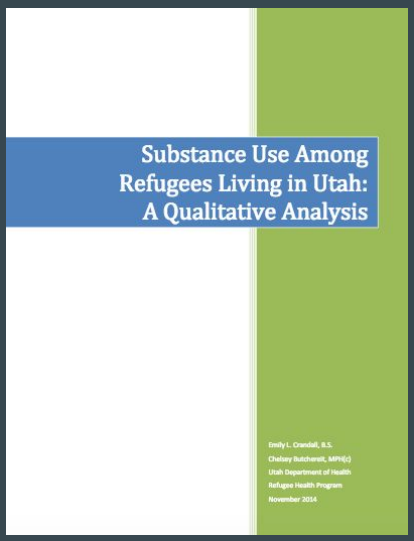
FINDINGS FROM UTAH

- ➔ Qualitative analysis of 37 anecdotal accounts from service providers[58]
  - Included information about resettled refugees from Burundi, Bhutan, Congo, Burma, Sudan, and South Sudan
  - Higher frequency of married males who had been in U.S. for 4 years on average and were unemployed
  - Alcohol was most commonly used; other drugs reported but not specified
  - Little information about recovery or treatment options

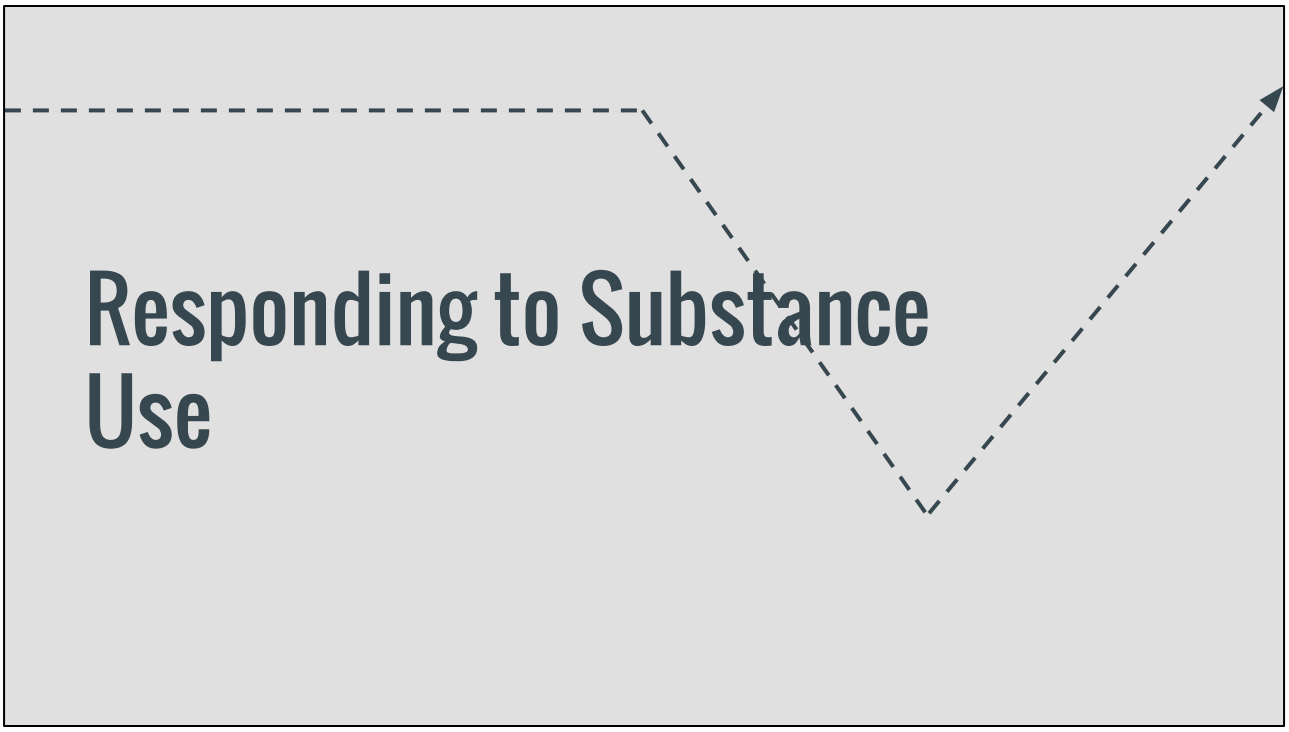
To provide an example of how these risk factors may apply to some resettled refugees, in 2014, the Utah Department of Health conducted a qualitative analysis to identify substance use trends among resettled refugees in the state.[58] Due to methodological limitations, results of the analysis cannot be generalized, but nonetheless provide an initial understanding of substance use patterns among refugees in this particular context--similar to the rapid assessment approach that has been used by humanitarian groups in refugee camp settings.[23] The 37 anecdotal accounts were collected from community resource specialists and other service providers working with individuals from Burundi, Bhutan, Congo, Burma, Sudan, and South Sudan.[58] Among clients using substances, service providers reported a higher frequency of married males who had been in the United States for an average of 4 years and were struggling with unemployment.[58] Alcohol was the most commonly used substance; illicit drug use was also reported, but substances were not specified. Service providers offered little information about recovery or treatment options accessed by refugees.

FINDINGS FROM UTAH

- Reported a number of legal, social, and health consequences:[58]
  - Driving under the influence
  - Family and spousal conflict
  - Domestic violence
  - Child welfare involvement
  - Chronic unemployment
  - Physical health problems
  - Mental health disorders



The accounts did document a number of legal, social, and health consequences related to substance use, including DUI, family and spousal conflict, domestic violence, child welfare involvement, and chronic unemployment, as well as physical health problems and co-occurring mental health disorders.[58] These outcomes are consistent with the literature we have reviewed in this module. Click on the report to read more.



Given the risk factors we have discussed, how might public health practitioners and service providers respond to substance use among resettled refugees?

AVAILABLE EVIDENCE

- ➔ More evidence needed about substance use among resettled refugees and interventions that may work best with specific groups
- ➔ Starting with existing evidence about global standards for substance use treatment, refugee mental health, and barriers to care

Despite anecdotal accounts about substance use as a concern among some resettled refugees, there is still much to learn about substance use in this population, and more evidence is needed about interventions that may work best with specific refugee groups. A number of effective substance use interventions exist, but largely have not been adapted for populations affected by conflict.[15] The majority of available recommendations for the management of substance use disorders among refugees come from global health sources that address substance use in humanitarian settings.[15] Still, the basic principles of these recommendations--to minimize harm related to substance use and address its underlying causes--are also relevant in the resettlement context. The evidence we have about refugee mental health and common barriers to care can also provide a starting point for considering implications for practice with resettled refugees.

GLOBAL SUBSTANCE USE TREATMENT STANDARDS

- ➔ Integrate substance use screening, brief intervention, and referral to treatment (SBIRT) into other services, including primary care and mental health settings[1,59]
- ➔ Increase availability of psychosocial support; community-based interventions[59]
- ➔ Increase availability of medication-assisted treatment (MAT) as appropriate[15,59]
- ➔ Ensure availability of gender-specific treatment options[1,20]
- ➔ Use a trauma-informed approach that is respectful and empowering[1]

Global standards for substance use treatment, set by the World Health Organization, include: integrating substance use prevention and brief intervention into other services offered to refugees, including routine screening in primary care and mental health settings; increasing availability of psychosocial support, including community-based interventions; increasing availability of medication-assisted treatment; ensuring availability of gender-specific treatment options; and using a trauma-informed approach that is respectful and empowering to clients.[1,15,20,59]

CHALLENGES IN REFUGEE MENTAL HEALTH

- ➔ Diversity of cultural backgrounds, pre-flight trauma, and flight experiences[8]
- ➔ Cross-cultural similarities and differences in presentation and meaning of distress, as well as accepted approaches for responding to distress[8]
- ➔ Cultural appropriateness of interventions, workforce, language needs, and cultural barriers that affect service acceptability and utilization[7,8]
- ➔ Changing policy landscape affecting resettlement programs and health services[8,60]

Challenges related to addressing refugee mental health may affect efforts to implement substance use interventions that incorporate global standards. First, although the refugee experience is defined by certain common elements, refugee groups and individuals are incredibly diverse in terms of cultural background, pre-flight trauma, and flight experiences.[8] Different groups vary in how they express and cope with distress, which can make it difficult for providers to identify and talk about distress with diverse refugee clients.[8] The relative cultural appropriateness of services can affect the degree to which services are accepted and used by particular communities.[7,8] Finally, the ever-changing policy landscape that shapes refugee resettlement and access to health services presents substantial challenges to promoting the mental health of refugee populations.[8,60]

BARRIERS TO SCREENING

- No routine screening for substance use among resettled refugees[2,24,26,40]
  - Cultural perceptions and practices
  - Language and terminology
  - Ethical considerations
  - Lack of screening tools validated with refugees

- Screening tools developed for global settings[2]
  - AUDIT (Alcohol Use Disorders Identification Test)
  - DUDIT (Drug Use Disorders Identification Test)
  - ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)

Although screening is a recommended practice for managing substance use, resettled refugees are not routinely screened for substance use. A study examining the experiences of Southeast Asian refugees confirmed that "few medical, mental health, or social service agencies systematically screen for [substance use]" among these clients, despite potential health consequences, such as undermining treatment goals, complicating medical or psychiatric diagnoses, and exacerbating physical symptoms or emotional distress.[2]

Screening for substance use among refugees presents distinct difficulties. As we have discussed, substance use is a culturally and socially situated behavior.[24] Accordingly, perceptions and practices around substance use may differ significantly among refugee groups. For many groups, substance use is highly stigmatized, while for others, substance use may be so normalized that it is not seen as problematic by an individual, even when others (such as family members or service providers) observe that the behavior is causing harm.[2,26] Both stigma and normalization may have an impact on screening in terms of what clients are likely to disclose about their substance use. Language may pose a barrier; in particular, the clinical language and concepts used by providers to discuss substance use may not translate precisely to languages spoken by resettled refugees. Further, there are ethical considerations about

whether appropriate treatment will be available to refugees who screen positive for substance use, and how identifying substance use may result in further stigma or affect an individual's employment, legal status, or eligibility for other services.[40]

A search of the literature found no screening tools that had been validated with refugee groups specifically, although several standardized tools have been used for research and practice in global settings, including refugee camps.[2] These tools include the Alcohol Use Disorders Identification Test, the Drug Use Disorders Identification Test, and the Alcohol Smoking and Substance Involvement Screening. All are brief screening approaches for adults, intended to indicate the presence of problematic substance use and explore its behavioral impact to inform next steps for intervention or referral. Because these tools have been validated with a variety of groups internationally, they may be useful options for work with resettled refugees. The links provided here include more information about each tool.

BARRIERS TO EXISTING SERVICES

- ➔ Differing cultural beliefs about mental health and substance use[4,7]
- ➔ Limited knowledge of substance use and its health effects[4,7]
- ➔ Lack of familiarity with existing treatment options[7]
- ➔ Lack of culturally informed treatment models[7]

Beyond the barriers posed by screening, resettled refugees face barriers to accessing existing treatment and support services for mental health and substance use. These barriers include differing cultural beliefs and attitudes about mental health and substance use, as well as limited knowledge of substance use and its health effects among some refugee groups.[4,7] Furthermore, resettled refugees are often unfamiliar with existing treatment options in the United States, and these options rarely incorporate culturally specific models for addressing substance use.[7]

BARRIERS TO EXISTING SERVICES

- ➔ Trauma, including previous abuse by health providers[4]
- ➔ Language barriers and lack of qualified interpreters[4]
- ➔ Time-limited benefits during initial resettlement[44]
- ➔ Other logistics, including transportation and childcare[4]

Trauma symptoms sometimes create a barrier to accessing substance use treatment services. Clinical settings can recall abuse by health providers that refugees may have experienced in their countries of origin or during other parts of the migration process, making it difficult to feel safe in seeking formal treatment services.[4] Language barriers and a lack of qualified interpreters can make services difficult to access.[4] As we have mentioned, refugees may have difficulty accessing services following initial resettlement due to the time-limited nature of the benefits they receive, including health insurance.[44] Finally, as with other services, logistics like transportation and childcare can be barriers to substance use treatment.[4]

CONNECTING REFUGEES TO TREATMENT

- ➔ Lack of culturally, linguistically informed programs
- ➔ Client characteristics, including trauma history and motivation
- ➔ Need to prepare clients for treatment experience itself and closely coordinate care

Connecting Refugees to Substance Use Treatment: A Qualitative Study

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ABSTRACT

An emerging body of literature identifies substance use as a growing concern among refugees resettling in the United States. Like immigrants, refugees may face cultural, linguistic, or systems barriers to connecting with mainstream substance use treatment programs, which may be compounded by refugees' unique experiences with exposure to trauma, displacement in refugee camps, and resettlement. This qualitative study explores factors that support and prevent refugees from connecting with chemical health treatment. Fifteen participants who identified as social service or public health professionals who work with refugees responded to an online, semistructured survey about their experiences referring refugees to substance use treatment. Resulting data was analyzed using thematic analysis. Themes emerged identifying a lack of culturally informed treatment models, policy issues, and client characteristics such as motivation and past trauma as barriers to engaging with treatment. Ongoing case management and coordination were identified as important to successful linkage. Findings from this study contribute to a better understanding of how to support refugees seeking substance use treatment and suggest that developing trauma informed, culturally relevant models of treatment that are integrated with primary health care and geographically accessible may enhance treatment linkage.

KEYWORDS

Refugees; substance use treatment; referrals; coordination of care

Source: McCleary JS, Shannon PJ, Cook TL. Connecting Refugees to Substance Use Treatment: A Qualitative Study. *Soc Work Public Health.* 2016;31(1):1-8.

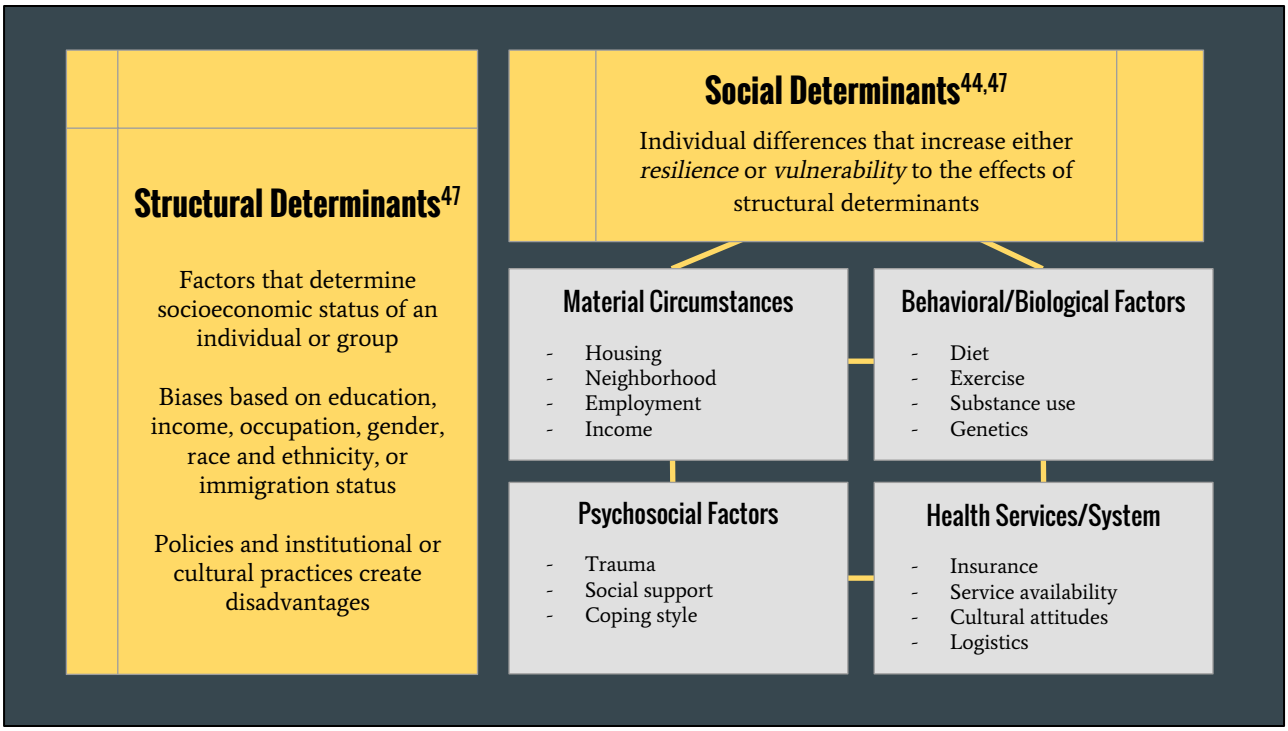
A recent qualitative study on connecting refugees to substance use treatment confirmed these barriers. Surveys conducted with service providers who had attempted to refer refugee clients to substance use treatment revealed several themes. First, providers reported difficulty making referrals due to a lack of treatment programs that were culturally and linguistically informed to meet the needs of refugee clients; some programs were unable or unwilling to accept clients who did not speak English, and at least one client who met criteria for a certain level of care was unable to access it due to the lack of available interpretation services.[4] Next, providers noted that client characteristics such as motivation and complex trauma history sometimes complicated the referral process. Clients whose family members requested a referral tended to be less successful than clients who self-identified a desire or need for treatment; others found it difficult to engage with treatment long-term due to trauma symptoms.[4] These challenges are similar to those posed by substance use treatment referrals with U.S.-born populations, but may require even more intensive efforts with refugee clients due to the additional barriers they face. A related theme among providers was the need to spend significant time building trust and preparing clients for the treatment experience itself before making a referral.[4] In every situation where providers reported a successful linkage to

treatment, they described remaining involved to closely coordinate care and follow up on progress with both the client and the treatment agency.[4]

SOCIAL DETERMINANTS OF MENTAL HEALTH

- ➔ Social determinants of mental health (SDMH) framework is a useful tool for considering practice implications around refugee substance use:[44]
  - ◆ Structural and sociocultural factors, in addition to individual circumstances, shape adjustment patterns and affect long-term mental health outcomes
- ➔ Understanding individual pre-migration and flight experiences is important for providing responsive mental health and substance use services[8]
- ➔ The well-being of resettled refugees also depends on the "willingness and resourcefulness of host countries" in providing support[47]

Given what we have learned about the risk factors for substance use among refugees and the barriers they face when accessing services, a social determinants of mental health framework is a useful tool for considering practice implications.[44] The framework states that structural and sociocultural factors, in addition to individual circumstances, shape adjustment patterns of refugees resettled in the United States and affect their long-term mental health outcomes.[44] Understanding refugees' experiences during pre-migration and flight are important for providing responsive mental health and substance use services in the context of resettlement.[8] As we know, individual mental health status is a major factor that affects risk for substance use. At the same time, researchers are increasingly realizing that the well-being of resettled refugees depends not only on their personal or group characteristics, but also on the "willingness and resourcefulness of host countries" in providing support.[47]



Structural determinants are the factors that determine the socioeconomic status of an individual or group. Biases based on education, income, occupation, gender, race/ethnicity, or immigration status result in policies and institutional or cultural practices that disadvantage certain groups, such as refugees.[47] In general, lower socioeconomic status is associated with worse physical and mental health outcomes.[61]

Social determinants are the individual differences that may increase either resilience or vulnerability to the effects of structural determinants.[44,47] Types of social determinants include: material circumstances (such as housing, neighborhood environment, and income), psychosocial factors (including trauma history, social support, and coping style), behavioral and biological factors (such as diet, exercise, and genetic predisposition), and factors related to the health system (including insurance coverage, availability of services, and logistics like transportation).[47] As we have discussed throughout the module, many of these social determinants affect an individual's risk for substance use, in addition to other physical and mental health outcomes.

SOCIAL DETERMINANTS OF MENTAL HEALTH

- ➔ In one study, post-resettlement factors were associated with refugees' self-rated mental health status, while pre-flight trauma was not associated[44]
- ➔ Suggests that refugees may prioritize addressing immediate stressors of resettlement over processing past traumas[8,44]
- ➔ Balancing awareness of trauma with emphasis on promoting resilience and psychosocial support in context of resettlement[8,44]
- ➔ A three-dimensional model for intervention: 1) individual or treatment level, 2) community or service level, 3) systems or institutional level[47]

What might the social determinants of health framework mean for addressing substance use with resettled refugees? To begin with, it emphasizes the importance of considering an individual's context when assessing any behavioral health needs. In one study, post-resettlement factors (including discrimination, unemployment, and neighborhood environment) were significantly associated with refugees' mental health status, but pre-flight trauma was *not* significantly associated with mental health, per refugees' self reports.[44] These findings suggest that refugees may prioritize addressing the immediate stressors of resettlement over processing past traumas, and point to a need for service providers to balance an awareness of trauma with an emphasis on promoting resilience and psychosocial support in the context of resettlement.[8,44]

The social determinants of mental health framework calls for a three-dimensional model for intervention that addresses mental health and substance use at the individual or treatment level, the community or service level, and the systems or institutional level.[47] Based on this model, let's consider implications for practice with resettled refugees experiencing or at risk for substance use. These implications are based on existing evidence related to refugee mental health as well as emerging evidence about substance use among refugees.

IMPLICATIONS: INDIVIDUAL/TREATMENT LEVEL

- ➔ Solicit and respond to clients' own explanations of substance use and its function in their lives (rather than discussing only a medical model)[47]
- ➔ Frame conversations about substance use in terms of health; ask about various methods used to relieve stress or physical pain[2,47]
- ➔ Ensure that refugees have access to adequate interpretation in service settings[4]
- ➔ Recognize the potential impact of displacement and migration on clients' mental health status and risk for substance use, but remember that individual clients have varying experiences[8]

On the individual or treatment level, the following approaches may be useful for addressing substance use with clients who are resettled refugees:

· Begin by soliciting and responding to clients' own explanations of substance use and its function in their lives (rather than discussing only a medical model); remember that some clients may view substances as having a positive function.[47]

· To minimize stigma, frame conversations about substance use in terms of health, and ask about various methods that clients use to relieve stress or physical pain. These methods may include substance use.[2,47]

· Ensure that refugees have access to adequate interpretation in service settings.[4]

· Recognize the potential impact of displacement and migration on clients' mental health and risk for substance use, but remember that individual clients have varying experiences.[8]

IMPLICATIONS: INDIVIDUAL/TREATMENT LEVEL

- ➔ Incorporate trauma-informed approaches to care, but remember that individual clients may experience and cope with trauma in different ways[1,8]
- ➔ Do not underestimate material and social factors beyond trauma that may affect clients; work to connect clients with resources to meet basic needs[4,8,47]
- ➔ Consider family and community context--and the role of family and community support--for clients experiencing substance use[1,8]
- ➔ Be attentive to possible substance use in crisis situations, such as incidents of family violence[2]

· Incorporate trauma-informed approaches to care but remember that individual clients may experience and cope with trauma in different ways.[1,8] Click the link for further information on trauma-informed care.

· At the same time, do not underestimate material and social factors beyond trauma that may affect clients' mental health and risk for substance use in resettlement.[4,8,47] Work to connect refugees to resources that address broader material and social needs such as assistance with housing, food, and employment.[47]

· Consider family and community context--and the role of family and community support--for clients experiencing substance use.[2,8]

· Finally, be attentive to possible substance use in crisis situations, such as incidents of family violence.[2]

IMPLICATIONS: COMMUNITY/SERVICE LEVEL

- ➔ Work across professional boundaries to facilitate communication, coordinate services, and identify service gaps[47]
- ➔ Build on existing relationships of trust with service providers; even if they do not directly provide substance use treatment, they can contribute to social support
- ➔ Offer education about substance use to service providers who interact with resettled refugees in various settings
- ➔ Identify opportunities for health promotion and dialogue about substance use with refugee community members, in settings where they feel comfortable[7]

Next, these approaches may be helpful in formulating responses to refugee substance use at the community or service level:

· Work across traditional professional boundaries to facilitate communication, coordinate services, and identify gaps in available services.[47]

· Build on existing relationships of trust with service providers; clients are more likely to discuss concerns like substance use with service providers they already trust.[2] Even if they do not directly provide substance use treatment, they can contribute to clients' social support, which may improve mental health status and facilitate behavior change.

· Offer education about substance use to service providers who interact with resettled refugees in various settings.

· Despite the barriers that refugees face, “research suggests there is a window of opportunity in which newcomers are quite receptive to learning about substance [use]."[7] Identify opportunities for health promotion and dialogue about substance use with interested refugee community members, in settings where they feel comfortable.

IMPLICATIONS: COMMUNITY/SERVICE LEVEL

- ➔ Build capacity in refugee communities by working with leaders to facilitate participation in training, decision-making, and service planning[7,47]
- ➔ Remember that effective interventions may not look like typical medical model approach
- ➔ Psychosocial models engaging individuals, families, and communities may be more acceptable to some communities[8]

· Build capacity in refugee communities by working with leaders to develop a shared understanding of substance use and facilitate participation in training, decision-making, and service planning.[7,47]

· More intervention research is needed; however, existing evidence suggests that effective interventions may not look like treatment based on a medical model; psychosocial models that engage individuals, families, and communities may be more acceptable to some communities.[8]

IMPLICATIONS: SYSTEMS/INSTITUTIONAL LEVEL

- ➔ Identify areas for advocacy with and on behalf of refugee communities to improve health access and promote integration[47]

- ➔ Collaborate with refugee-led organizations to solicit input about health services as well as support their existing programming and advocacy efforts[47]
- ➔ This collaboration may provide a better understanding of community resilience and protective factors that can inform responses to substance use

Finally, at the systems or institutional level, these approaches may promote the wellbeing of refugees by addressing broader conditions that increase risk for substance use:

· Identify areas for advocacy with and on behalf of refugee communities to improve their access to health services (including mental health and substance use treatment and support) and promote opportunities for legal, economic, and social integration.[47]

· Collaborate with refugee-led organizations to solicit input about health services as well as support their existing programming and advocacy efforts.[47] This collaboration may provide practitioners with a better understanding of community resilience and protective factors that may inform effective responses to substance use prevention, treatment, and support among resettled refugees.

CONCLUSIONS

- ➔ There is still much to learn about substance use patterns among resettled refugees, as well as interventions that are most effective for particular groups
- ➔ Research suggests that responses to substance use treatment will likely require culturally tailored approaches to treatment and support
- ➔ Raising awareness of this issue among public health practitioners and service providers is crucial given the health and social consequences of substance use
- ➔ Reviewing existing evidence may enhance efforts to understand and respond to substance use among resettled refugees

There is still much to learn about substance use patterns among resettled refugees, as well as interventions that are most effective for particular groups. Nonetheless, raising awareness of this issue among public health practitioners and service providers is crucial given the health and social consequences that substance use can have for refugee individuals, families, and communities. Research suggests that responses to substance use in refugee communities will likely require culturally tailored approaches. Starting with an understanding of the refugee experience, global substance use patterns, unique risk factors, and identified practices for addressing refugee mental health may enhance efforts to understand and respond to substance use among resettled refugees, as evidence continues to emerge about more comprehensive interventions.

Feedback

Please complete the following survey to provide feedback on this module.

This concludes the module. Please click the link to complete a survey and provide feedback.

Thank You

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ADDITIONAL RESOURCES

UNC Refugee Mental Health & Wellness Initiative
University of North Carolina at Chapel Hill

Harvard Program in Refugee Trauma
Harvard University

National Partnership for Community Training
Gulf Coast Jewish Family & Community Services

Refugee Health Technical Assistance Center
Massachusetts Department of Health

ADDITIONAL RESOURCES

Educational Module: Immigrants, Refugees, and Alcohol
National Institute for Alcohol Abuse and Alcoholism

Webinar: Substance Abuse and the Torture Survivor Experience
National Partnership for Community Training

Presentation: Trauma-Informed Care for Refugees--Building Awareness, Skills, and Knowledge
Nancy Murakami, Bellevue/NYU Program for Survivors of Torture

Presentation: Understanding and Responding to Harmful Alcohol Use in a Refugee Community
Jennifer McCleary, Tulane School of Social Work

REFERENCES

1. Horyniak D, Melo JS, Farrell RM, Ojeda VD, Strathdee SA. Epidemiology of substance use among forced migrants: A global systematic review. *PLoS One*. 2016;11(7):e0159134. doi:10.1371/journal.pone.0159134.
2. Amodeo M, Robb N. Alcohol and other drug problems among Southeast Asians: patterns of use and approaches to assessment and intervention. *Alcohol Treat Q*. 1997;15(3):63-77. doi:10.1300/J020v15n03.
3. Drachman D. A stage-of-migration framework for service to immigrant populations. *Soc Work*. 1992;37(1):68-72. doi:10.1093/sw/37.1.68.
4. McCleary JS, Shannon PJ, Cook TL. Connecting refugees to substance use treatment: A qualitative study. *Soc Work Public Health*. 2016;31(1):1-8. doi:10.1080/19371918.2015.1087906.
5. Weaver H, Roberts B. Drinking and displacement: a systematic review of the influence of forced displacement on harmful alcohol use. *Subst Use Misuse*. 2010;45(13):2340-2355. doi:10.3109/10826081003793920.
6. Durrant R, Thakker J. *Substance Use and Abuse: Cultural and Historical Perspectives*. Los Angeles: Sage Publications; 2003.
7. Leow DM, Goldstein M, Mcglinchy L. *A Selective Literature Review: Immigration, Acculturation & Substance Abuse*. Educational Development Center. Boston; 2006.
8. Murray KE, Davidson GR, Schweitzer RD. Review of refugee mental health interventions following resettlement: Best practices and recommendations. *Am J Orthopsychiatry*. 2010. doi:10.1111/j.1939-0025.2010.01062.x.
9. Columbia University Mailman School of Public Health. *Forced Migration Learning Module*. http://www.columbia.edu/itc/hs/pubhealth/modules/forcedMigration/definitions.html. Published 2016. Accessed September 30, 2016.
10. UNHCR. Figures at a glance. http://www.unhcr.org/en-us/figures-at-a-glance.html. Published 2015. Accessed July 15, 2016.
11. UNHCR. What is a refugee? http://www.unrefugees.org/what-is-a-refugee/. Published 2016. Accessed July 30, 2016.

REFERENCES

12. Drachman D, Halburstadt A. A stage of migration framework as applied to recent Soviet emigres. *J Multicult Soc Work*. 1992;2(1):63-78.
13. Sowey H. *Are Refugees at Increased Risk of Substance Misuse?* Drug and Alcohol Multicultural Centre. Redfern, New South Wales, Australia; 2005.
14. Johnson T. Alcohol and drug use among displaced persons: An overview. *Subst Use Misuse*. 1996;31(13):1853-1889.
15. Ezard N, Oppenheimer E, Burton A, et al. Six rapid assessments of alcohol and other substance use in populations displaced by conflict. *Confl Health*. 2011;5(1):1. doi:10.1186/1752-1505-5-1.
16. Loescher G, Milner J. Protracted displacement: Understanding the challenge. *Forced Migr Rev*. 2009;(33):9-11.
17. UNHCR. Resettlement. http://www.unhcr.org/en-us/resettlement.html. Published 2016. Accessed July 15, 2016.
18. Zong J, Batalova J. Refugees and Asylees in the United States. Migration Information Source. http://www.migrationpolicy.org/article/refugees-and-asylees-united-states. Published 2015. Accessed September 19, 2016.
19. US Department of State. Fiscal Year 2016 Refugee Admissions. http://www.state.gov/r/pa/prs/ps/2016/10/262776.htm. Published 2016. Accessed September 19, 2016.
20. Roberts B, Ezard N. Editorial: Why are we not doing more for alcohol use disorder among conflict-affected populations? *Addiction*. 2015;110(6):889-890.
21. Health Officers Council of British Columbia. *A Public Health Approach to Drug Control in Canada*. Victoria, British Columbia; 2005.
22. World Health Organization. Substance abuse. http://www.who.int/topics/substance_abuse/en/. Published 2016. Accessed September 19, 2016.

REFERENCES

23. UNHCR, World Health Organization. *Rapid Assessment of Alcohol and Other Substance Use in Conflict-Affected and Displaced Populations: A Field Guide*. Geneva, Switzerland; 2008.
24. World Health Organization. *ATLAS on Substance Use: Resources for the Prevention and Treatment of Substance Use Disorders*. Geneva, Switzerland; 2010.
25. World Health Organization. *Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks*. Geneva, Switzerland; 2009.
26. Ezard N, Thiptharakun S, Rhodes T, Nosten F, McGready R. Risky alcohol use among reproductive-age men, not women, in Mae La refugee camp, Thailand, 2009. *Confl Health*. 2012;6(1):7. doi:10.1186/1752-1505-6-7.
27. Spiegel PB, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. *Lancet*. 2010;375(9711):341-345. doi:10.1016/S0140-6736(09)61873-0.
28. Streel E, Schilperoord M. Perspectives on alcohol and substance abuse in refugee settings: lessons from the field. *Intervention*. 2010;8(3):268-275 10.1097/WTF.0b013e328341315f. doi:10.1097/WTF.0b013e328341315f.
29. World Health Organisation. The WHO global strategy to reduce the harmful use of alcohol. *Alcohol and Alcoholism*. 2010;46(3):1-44. doi:10.1093/alcalc/agr035.
30. UNODC. *World Drug Report 2015*. Vienna, Austria; 2015. doi:10.1017/CBO9781107415324.004.
31. Meng G. *A Price Too High: U.S. Families Torn Apart by Deportations for Drug Offenses*. Human Rights Watch; 2013.
32. ACLU, Detention and Deportation Working Group. *Briefing Materials Submitted to the United Nations Special Rapporteur on the Human Rights of Migrants*. 2007.

REFERENCES

33. World Health Organization. Management of substance abuse: The global burden. http://www.who.int/substance_abuse/facts/global_burden/en/. Accessed September 20, 2016.
34. World Health Organisation. *Global Status Report on Alcohol and Health*. Geneva, Switzerland; 2014.
35. World Health Organization. Prevalence of alcohol use disorders (%), adult males and females (15 years and above), 2004. Resources for the Treatment and Prevention of Substance Use Disorders. http://gamapserver.who.int/gho/interactive_charts/substance_abuse/bod_alcohol_prevalence/atlas.html. Published 2004. Accessed September 25, 2016.
36. World Health Organization. Main psychoactive substances accountable for treatment entry, 2008. Public Health Information and Geographic Information Systems. http://gamapserver.who.int/mapLibrary/Files/Maps/Global_psychoactive_substances_2008.png. Published 2012. Accessed September 25, 2015.
37. World Health Organization. Most commonly used treatment setting for the treatment of alcohol and drug use disorders. Resources for the Treatment and Prevention of Substance Use Disorders. http://gamapserver.who.int/gho/interactive_charts/substance_abuse/treatment_alcohol_drugs/atlas.html. Published 2008. Accessed September 25, 2016.
38. World Health Organization. Implementation of screening and brief treatment for substance use and substance use disorders in primary health care, 2008. Resources for the Treatment and Prevention of Substance Use Disorders. http://gamapserver.who.int/gho/interactive_charts/substance_abuse/prevention/atlas.html. Published 2012. Accessed September 25, 2016.
39. National Institute on Alcohol Abuse and Alcoholism. *Immigrants, Refugees, and Alcohol: NIAAA Social Work Education Module 10F*. http://pubs.niaaa.nih.gov/publications/Social/Module10FImmigrants&Refugees/Module10F.html. Published 2005. Accessed July 30, 2016.

REFERENCES

40. National Partnership for Community Training. *Substance Abuse and the Torture Survivor Experience*. Clearwater, FL; 2014.
41. Salas-Wright CP, Vaughn MG. A "refugee paradox" for substance use disorders? *Drug Alcohol Depend*. 2014;142:345-349. doi:10.1016/j.drugalcdep.2014.06.008.
42. Acevedo-Garcia D, Bates LM. Latino health paradoxes: Empirical evidence, explanations, future research, and implications. In: *Latinas/os in the United States: Changing the Face of America*. Springer US; 2008.
43. Centers for Disease Control. Technical Instructions for Physical or Mental Disorders with Associated Harmful Behaviors and Substance-related Disorders for Panel Physicians. http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/mental-panel-technical-instructions.html. Published 2015. Accessed July 9, 2016.
44. Kim I. Beyond trauma: Post-resettlement factors and mental health outcomes among Latino and Asian refugees in the United States. *J Immigr Minor Heal*. 2015;18(4):740-748. doi:10.1007/s10903-015-0251-8.
45. Center for Victims of Torture. *Healing the Hurt: A Guide for Developing Services for Torture Survivors*. Minneapolis, MN; 2015.
46. Refugee Health Technical Assistance Center. Traumatic experiences of refugees. http://refugeehealthta.org/physical-mental-health/mental-health/adult-mental-health/traumatic-experiences-of-refugees/. Published 2011. Accessed October 1, 2016.
47. Kim I, Kim W. Post-resettlement challenges and mental health of Southeast Asian refugees in the United States. *Best Pract Ment Heal*. 2014;10(2):63-78.
48. Savin D, Seymour DJ, Littleford LN, Bettridge J, Giese A. Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Rep*. 2005;120(3):224.

REFERENCES

49. Refugee Health Technical Assistance Center. Mental health. http://refugeehealthta.org/physical-mental-health/mental-health/. Published 2016. Accessed September 30, 2016.
50. Yoshimasu K. Substance-related disorders and somatic symptoms: How should clinicians understand the associations? *Curr Drug Abuse Rev*. 2012;5(4):291-303. https://www.ncbi.nlm.nih.gov/pubmed/23244342.
51. Brown S, Bean F. Assimilation Models, Old and New: Explaining a Long-Term Process. Migration Information Source. http://www.migrationpolicy.org/article/assimilation-models-old-and-new-explaining-long-term-process. Published 2006. Accessed September 1, 2016.
52. Kozaric-Kovacic D, Ljubin T, Grappe M. Comorbidity of posttraumatic stress disorder and alcohol dependence in displaced persons. *Croat Med J*. 2000;41:173-178.
53. Carballo M, Nerukar A. Migration, refugees, and health risks. *Emerg Infect Dis*. 2001;7(3):556-560. doi:10.3201/eid0707.017733.
54. UNHCR. Mid-year trends 2015. http://www.unhcr.org/en-us/statistics/unhcrstats/56701b969/mid-year-trends-june-2015.html. Published 2015. Accessed July 30, 2016.
55. Tendayi A. Beyond prejudice: Structural xenophobic discrimination against refugees. *Geo J Int'l L*. 2014;45:323–589.
56. Bloch A. *Refugees' Opportunities and Barriers in Employment and Training*. Goldsmith College, University of London; 2002.
57. U.S. Department of State. *Refugee Admissions Reception & Placement Program*. Washington, DC; 2011.
58. Crandall E, Butchereit C. *Substance Use Among Refugees Living in Utah: A Qualitative Analysis*. Utah Department of Health. Salt Lake City UT; 2014.

REFERENCES

59. Dua T, Barbui C, Clark N, et al. Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: Summary of WHO recommendations. *PLoS Med*. 2011;8(11). doi:10.1371/journal.pmed.1001122.

60. Barkdull C, Weber B, Phillips A. The changing context of refugee resettlement policy and programs in the united states. *J Int Soc issues*. 2012;1(1):107-119.

61. Pappas G, Queen S, Hadden W, Fisher G. The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986. *N Engl J Med*. 1993;329(2):103-109.